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Privatizing the Public Sphere: Should Governments Outsource Health and Human Services?

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Privatizing the Public Sphere: Should Governments Outsource Health and Human Services?

Local governments in the state and across the country are trending towards outsourcing services to private companies. Although many of these services currently outsource to legal or technical companies to fill knowledge gaps among public employees, increasingly jurisdictions are turning to other types of services to help cut costs, including health and human services. For example, Michigan Governor Rick Snyder recently proposed privatizing billions of dollars worth of mental health funds — a move met with heavy backlash from citizens, mental health professionals and lobbyists. Though Snyder has since changed the wording in his budget proposal, the question remains: is privatizing health and human services useful for local governments? This paper aims to understand the issues surrounding outsourcing these services and analyze Snyder's proposal with this understanding.

At Issue: Local Governments Outsourcing Services

The history of local government privatization

Local and state governments have been turning toward outsourcing since the 1980s, and outsourced services saw a 60 percent increase from 1993 to 1997, according to the Council of State Governments (Chi et. al. 2004). Between the years 1997 and 2002, however, states reported not seeing much change in the amount of services outsourced of contracted out (Chi et. al. 2004). In these years, the number of privatization services remained moderate, with 12 of the 38 state

budget directors interviewed by the Council of State Government reporting an average of 6 percent of services contracted out (Government Business Council 2015). The reasons for outsourcing in these early years differed between state budget heads and state agency heads – the budget heads sought to cut costs, while agency heads used contracts to fill personnel or expertise gaps in the public sector (Government Business Council 2015). Most state agencies during this time reported only seeing an average of 0 to 5 percent of costs saved as a result of privatization, and believed the amount of privatized services would remain the same over the next five years (Government Business Council).

More recently, state and local governments have increased efforts to outsource services. A 2010 report by Tholons, found U.S. state governments alone can spend up to about $6 billion in outsourcing activities, and forecasted that the spending could go up to $11.4 billion by 2012 (Nichols 2010). Furthermore, a 2011 report by the Reason Foundation reported outsourcing in nearly all states and a 2011 report by the Council of State Government reported 200,000 active, formal agreements between local governments and private companies (Chi et. al. 2004).

Local governments privatize a range of their services, from parking assets, to zoos and libraries to public safety, according to a 2011 report from the Reason Foundation. Chicago, for example, has been a “hot bed” of privatization under Mayor Richard Daley, having outsourced or contracted out dozens of city services, tapping over $3 billion from long-term leases of city assets during his six-term, two-decade tenure (Gilroy et. al. 2010). Dallas and Tusla have moved to privatize their zoos, while many California municipalities – including Santa Clarita, San Joaquin County and Riverside County – moved to privatize or semi-privatize libraries from Library Systems & Services Inc. (Gilroy et. al. 2010). In July 2010, San Diego city attorney Jan Goldsmith proposed a ballot measure to help clear way for privatization of residential waste

collection, and Washington D.C., led by Mayor Adrian Fenty in 2009, announced plans to privatize the Detoxification and Stabilization Center (Gilroy et. al. 2010).

Benefits and drawbacks to privatize

The issue of outsourcing public services to private corporations or organizations is divisive among politicians, lobbyists and academics alike, in part due to mixed results seen from privatization. Former Michigan Governor John Engler once served as a proponent of outsourcing services during his tenure that ranged from 1991 to 2003, saying:

> It's my belief that the private sector is often better at getting the job done than government. First, the competition promotes operating cost effectively, and the greater accountability helps ensure quality products and services. The private sector also excels at using innovative technology to solve problems, while government agencies do not always have the same latitude to innovate or take risks. Finally, the private sector has vast resources in computer technology, high volume proceeding equipment, and specialized personnel, plus the flexibility to assign them wherever they are needed most.

Engler listed the three major reasons local governments choose to privatize services: 1) if a government monopolizes a certain area, privatization can encourage more competition and, subsequently, better service if moved to the private sector, 2) privatization may offer better, more sophisticated services and 3) privatizing services can fill information or expertise gaps within local governments (Chi et. al. 2004).

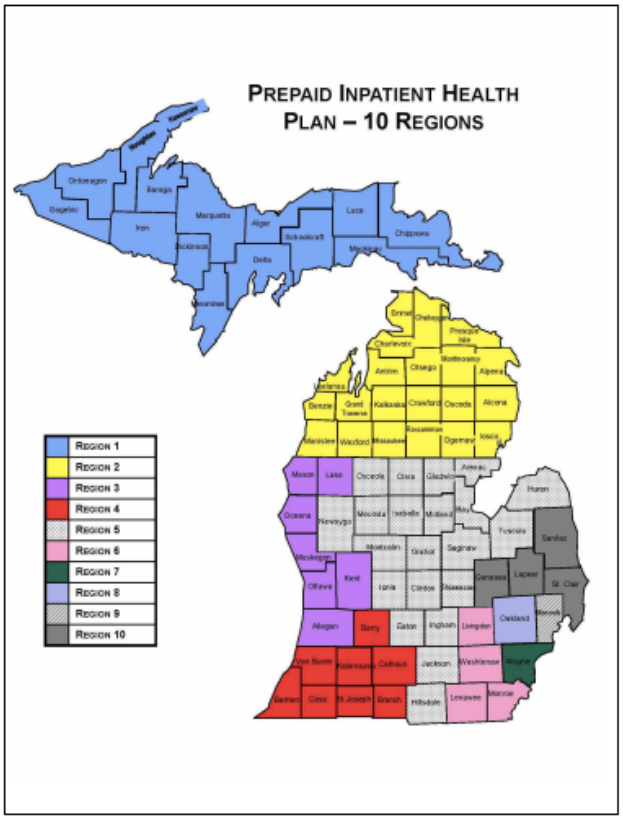
However, issues to privatization may exist. Federal restrictions to privatization exist, particularly in asset sales in state and local governments (Gilroy et. al. 2010). The move to privatize services also has not been seen to save much money – and in some cases can cost more.

For example, a study from the Project on Government Oversight analyzed 550 contracts between the federal government and private companies for 35 different jobs across government agencies, from auditors and engineers to food inspectors (Gilroy et. al. 2010). The study found private contractors cost more in 33 of 35 of the jobs, and service contracts paid private employees 83 percent more than the government would pay a federal employee for the same job (Gilroy et. al. 2010). Furthermore, The Council of State Governments found most state agencies saved less than 1 percent on privatization in areas like, education, health and human services, corrections and transportation (Gilroy et. al. 2010). Furthermore, just 3.9 percent of state agencies reported privatization led cost savings of more than 15 percent, whereas 18.4 percent reported no savings from privatization, and 10.5 percent of agencies reported savings of less than 1 percent (Gilroy et. al. 2010). Of the budget and legislative service agency directors in Arizona, Connecticut and Virginia who reported savings rates of over 15 percent, many officials in these states (32.6 percent of them) also reported not saving anything from privatization (Gilroy et. al. 2010). Other issues with privatization include not necessarily leading to more competition if none exists from privatization, the potential of hidden costs and corruption in cases of poorly conceived contracts and little oversight and an erosion of accountability and transparency (Gilroy et. al. 2010).

The final issue of privatization is the primary focus of this paper: whether or not governments should move to privatize health and human services, including mental health care. The Council of State Governments states: “contracting out facilities maintenance by a state agency has less serious implications as privatizing management of state prisons or running a mental health facility.” The next chapter of this paper will look into the “serious implication” contracting out mental health resources may have in Michigan, and the broader impacts of privatizing health and human services.

The Debate in Michigan: Outsourcing Mental Healthcare

The state of Michigan could become one of few states to outsource mental health services come 2017. Governor Rick Snyder's fiscal year 2017 budget calls for shifting $2.4 billion worth of mental health funding – including services for autism, substance abuse and serious behavioral disorders – to private health management organizations (Lessenberry 2016). To understand the implications of such a move, I will describe how the state organizes and provides mental health care, and then describe Snyder's proposal in more detail. Finally, I will describe the differing perspectives on the proposal in Michigan.



How mental healthcare is organized in the state

Currently, Michigan operates several types of managed care programs to provide health care services to Medicaid beneficiaries, including Medicaid Health Plans, Dental Programs and Prepaid Inpatient Hospital Plans, or PIHPs. PIHPs coordinate behavioral and social-service care for serious mental conditions, developmental disabilities and substance abuse. Since 1998, Michigan formed a separate system of regional public authorities to manage its now $2.4 billion plus Medicaid behavioral health budget for 230,000 patients (Buren 2016). Michigan's PIHPs are currently in 10 regions of the state (Figure A). The PIHPs in Michigan include: NorthCare Nework (which makes up all of the Upper Peninsula), Northern Michigan Regional Entity, Lakeshore Regional Entity, Southwest Michigan Behavioral Health, Mid-State Health Network, CMH Partnership of

Southeast Michigan, Detroit Wayne Mental Health Authority, Oakland County CMH Authority, and Macomb County Mental Health Services.

Snyder's bold proposal for mental healthcare

Snyder's proposal shifts the $2.4 billion that goes towards PIHPs to for-profit Health Management Organizations (Greene 2016). Nick Lyon, director of the Michigan Department of Health and Human Services, inserted the budget language (Greene 2016). The language, known as Section 298, called to privatize the $2.4 billion under the management of managed care organizations that would contract with the state (Greene 2016). After pushback from mental health officials, advocates for mental health, health providers and families of patients, the language was replaced with more inclusive wording that requires the Department of Health and Human Services to issue a report with recommendations to the state legislature in January on how to improve integration between physical and behavioral health systems in the state (Greene 2016). "I made the recommendation. Integration and improving services is very important to the governor," Lyon said. "Anything we can do to maximize services and better coordinate care is important to him and me (Greene 2016)."

The shift was not initially to save funds outright, but the Michigan Association of Health Plans, a nonprofit advocacy group for member health plans, suggests the switch could save millions of dollars in administrative fees (Voice 2016). However, experts are dubious the shift could actually cut costs – while administrative overhead costs for public PIHPs run between 6-7 percent, overhead at private health plans can be as high as 16 percent, according to the Michigan Association of Community Mental Health Boards, an advocacy group for public mental health care which has been lobbying against the budget proposal (Buren 2016). CEO of MACMHB Bob Sheehan said because of the higher administrative fees, private HMOs would need to reduce

services to meet the $200 million saved costs Snyder is proposing from the mental health outsourcing (Greene 2016). Furthermore, patients would receive either fewer care options from HMOs or different options than they are used to: while HMOs focus on psychotherapy and inpatient care, public facilities offer transportation, residential care and case management in addition to basic treatment (Buren 2016). Finally, PIHPs are more likely to treat patients with a severe mental health condition, while HMOs would likely run from investing in risky patients, said CEO of Detroit Wayne Mental Health Authority Tom Watkins (Greene 2016).

How different groups are reacting to Snyder's proposal

Since the public outcry against privatization of the mental health funds altogether, Snyder has changed the language to propose unifying care providers of both mental and physical health by allowing the Medicaid HMOs – separate from commercial HMOs – to manage the $10.4 billion managed Medicaid system for both types of healthcare (Greene 2016). Many representatives on all sides of this issue differ on how best to go forward with mental health care in Michigan.

John Kinch, executive director of Macomb County Community Mental Health and the Macomb PIHP said the organization has relationships with consumers of mental health services, and it has historical, local experiences with the people they serve: "The Medicaid health plans don't deal with those populations and never have," Kinch said. "They don't know the unique services we provide (Greene 2016)."

Sheehan believes funding needs to remain separate from private HMOs, but reforms can improve the current mental health system (Greene 2016). His suggestions include having a single PIHP instead of ten across the state and maintaining stringent public oversight (Greene 2016).

On the other hand, Jon Cotton, president and COO of Meridian Health Plan of Michigan says PIHPs are no longer efficient, and private health plans have more capital to invest in more services, white implementing care in a more cost-effective manner (Greene 2016).

Willie Brooks, executive director of the Oakland County Mental Health Authority, said he favors a reform plan that puts people — not HMOs and profits — first. PIHPs are required to redistribute excess dollars within their operations, he said, not to owners or shareholders: "It also is important that the system we have is driven by outcomes and not profitability (Greene 2016)."

Statistical Analysis

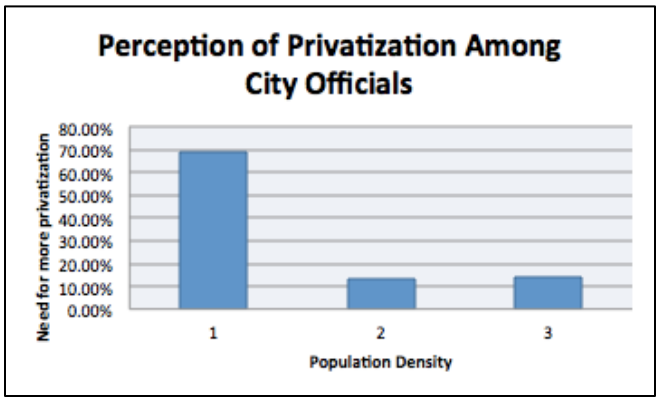
Survey data from Michigan legislators and citizen shows a troubling trend in the perceptions of privatization — although low-income residents, who would suffer most from increased privatization from health and human services, are opposed to more government privatization, city officials from low areas of Michigan would prefer more privatization, perhaps due to lack of resources to fund public operations.

Michigan representatives' perceptions of privatization

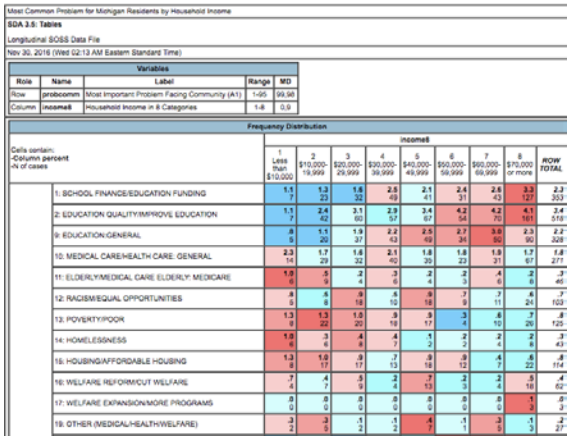
Most local governments in the state already outsource to private companies, and are satisfied with the results. Although most local governments would not change the amount of services privatized, the desire to outsource more is higher among low-density populations, perhaps due to dwindling funding given to these municipals.

65 percent of local governments currently contract out one or more public services or government operations, according to survey data from the Center for Local, State and Urban Policy, including 84 percent of the state's largest jurisdictions. Most local governments say they outsource to cut costs. Furthermore, 73 percent of local government officials report satisfaction with their experiences. However, only 6 percent of jurisdictions outsource health and human

services — compared to 83 percent that outsource to attorney/legal services, and 51 percent that outsource to engineering companies.



Rural governments in particular feel a stronger desire to outsource services. When divided through population density, rural governments were more likely to say there was "not enough" government outsourcing when compared to responses from medium and high population dense areas in the state (Figure B). This may in part be from local governments struggling to improve financially. According to a 2010 survey from MPPS, local governments with high and medium fiscal stress reported feeling less able to meet financial needs in 2010 than in years prior, and only 28 percent of local leaders reported believing their jurisdiction will be better able to meet its fiscal years in the coming years.


Most Common Problem for Michigan Residents by Household Income
SDA 3.5: Tables
Longitudinal SOSS Data File
Nov 30, 2016 (Wed 02:13 AM Eastern Standard Time)

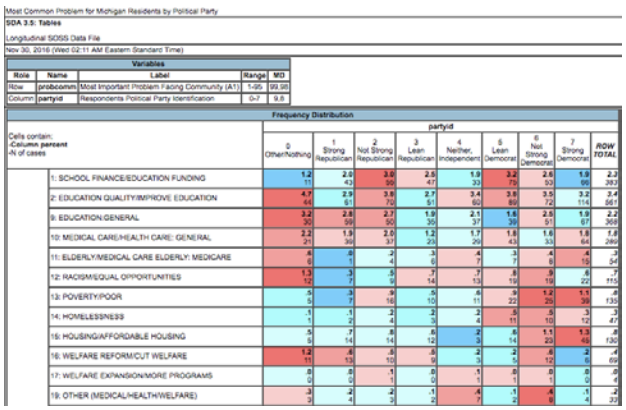
Variables

Role	Name	Label	Range	MD
Row	probcomm	Most Important Problem Facing Community (A1)	1-95	99,98
Column	income8	Household Income in 8 Categories	1-8	0,9

Frequency Distribution

Cells contain:
-Column percent
-N of cases

	income8	1 Less than $10,000	2 $10,000-19,999	3 $20,000-29,999	4 $30,000-39,999	5 $40,000-49,999	6 $50,000-59,999	7 $60,000-69,999	8 $70,000 or more	ROW TOTAL
1: SCHOOL FINANCE/EDUCATION FUNDING		1.1 7	1.3 23	1.8 32	2.6 49	2.1 41	2.4 31	2.6 43	3.3 127	2.3 353
2: EDUCATION QUALITY/IMPROVE EDUCATION		1.3 7	2.4 42	3.1 60	2.9 57	3.4 67	4.2 54	4.2 70	4.1 161	3.4 518
9: EDUCATION:GENERAL		.8 5	1.1 20	1.9 37	2.2 43	2.5 49	2.7 35	3.0 50	2.3 90	2.2 328
10: MEDICAL CARE/HEALTH CARE: GENERAL		2.3 14	1.7 29	1.8 32	2.1 40	1.8 35	1.9 23	1.9 31	1.7 67	1.8 271
11: ELDERLY/MEDICAL CARE ELDERLY: MEDICARE		1.0 6	.5 9	.2 4	.3 6	.2 4	.2 3	.4 6	.2 8	.3 46
12: RACISM/EQUAL OPPORTUNITIES		.8 5	.5 9	.9 18	.5 10	.9 18	.7 9	.7 11	.6 24	.7 103
13: POVERTY/POOR		1.3 8	1.3 22	1.0 20	.9 18	.9 17	.3 4	.6 10	.7 26	.8 125
14: HOMELESSNESS		1.0 6	.3 6	.4 8	.4 7	.1 2	.2 3	.2 4	.2 8	.3 43
15: HOUSING/AFFORDABLE HOUSING		1.3 8	1.0 17	.9 17	.7 13	.9 18	.9 12	.4 7	.6 22	.8 114
16: WELFARE REFORM/CUT WELFARE		.7 4	.4 7	.5 9	.2 4	.7 13	.2 3	.2 4	.0 18	.4 62
17: WELFARE EXPANSION/MORE PROGRAMS		.0 0	.0 0	.0 0	.0 0	.0 0	.0 0	.0 0	.1 3	.0 3
19: OTHER (MEDICAL/HEALTH/WELFARE)		.3 2	.2 3	.1 2	.1 2	.4 7	.1 1	.3 5	.1 3	.2 27


Most Common Problem for Michigan Residents by Political Party
SDA 3.5: Tables
Longitudinal SOSS Data File
Nov 30, 2016 (Wed 02:11 AM Eastern Standard Time)

Variables

Role	Name	Label	Range	MD
Row	probcomm	Most Important Problem Facing Community (A1)	1-95	99,98
Column	partyid	Respondents Political Party Identification	0-7	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

	partyid	0 Other/Nothing	1 Strong Republican	2 Not Strong Republican	3 Lean Republican	4 Neither, Independent	5 Lean Democrat	6 Not Strong Democrat	7 Strong Democrat	ROW TOTAL
1: SCHOOL FINANCE/EDUCATION FUNDING		1.2 11	2.0 43	3.0 59	2.5 47	1.9 33	3.2 79	2.6 63	1.9 66	2.3 363
2: EDUCATION QUALITY/IMPROVE EDUCATION		4.7 44	2.9 61	3.8 70	2.7 51	3.4 60	3.8 89	3.5 72	3.2 114	3.4 661
9: EDUCATION:GENERAL		3.2 30	2.8 59	2.7 50	1.9 35	2.1 37	1.6 39	2.0 51	1.9 67	2.2 366
10: MEDICAL CARE/HEALTH CARE: GENERAL		2.2 21	1.9 39	2.0 37	1.2 23	1.7 29	1.8 43	1.6 33	1.8 64	1.8 299
11: ELDERLY/MEDICAL CARE ELDERLY: MEDICARE		.4 4	.0 1	.2 4	.3 6	.4 7	.3 7	.4 9	.4 15	.3 54
12: RACISM/EQUAL OPPORTUNITIES		1.3 12	.3 7	.5 9	.7 14	.7 13	.8 19	.9 19	.6 22	.7 115
13: POVERTY/POOR		.5 5	.3 7	.3 6	.5 10	.6 11	.9 22	1.2 29	1.1 39	.8 130
14: HOMELESSNESS		.1 1	.1 2	.2 4	.2 4	.2 4	.3 8	.3 8	.3 12	.2 47
15: HOUSING/AFFORDABLE HOUSING		.5 5	.7 14	.8 14	.6 12	.2 3	.6 14	1.1 27	1.3 45	.8 130
16: WELFARE REFORM/CUT WELFARE		1.2 11	.6 13	.5 10	.5 9	.2 3	.2 5	.3 8	.2 8	.4 69
17: WELFARE EXPANSION/MORE PROGRAMS		.0 0	.0 1	.1 1	.0 1	.1 1	.0 1	.0 1	.0 0	.0 4
19: OTHER (MEDICAL/HEALTH/WELFARE)		.3 3	.2 4	.2 3	.1 2	.4 7	.1 2	.4 8	.1 4	.2 33

There are limits to the data that may interfere with making a strong conclusion based on the MPPS survey data. First, the survey asks very few questions directly relating to privatizing solely health and human services — despite the fact this area of outsourcing may present it's

own, unique, challenges. Furthermore, more crosstabs would be needed to assess different demographics' perceptions on outsourcing among local leaders. Although most rural communities are low-income, those that are financially stable would skew the data. Furthermore, many larger populations dense areas also struggle financially — a crosstab based on income would be more useful, especially when comparing to data from low-income Michigan residents, as analyzed below.

Michigan residents' perceptions of privatization

Low-income residents — who largely makeup rural areas of Michigan — are more trustworthy of local governments, suggesting a preference for local government services. For those impacted the most by the move – low-income households – they view healthcare as more of a problem, but trust local governments more than state governments. For example, data from the State of the State Survey administered by Michigan State University's Institute for Public Policy and Social Research found those with lower incomes, especially those with incomes less than $10,000 a year, view medical care and health care as the most important issue facing the community (Figure C). Furthermore, the results do not seem to differ along party lines for those of all income brackets (Figure D). What's more, those with lower incomes tend to trust the state government *less* than local governments, which is important since currently local municipals are responsible for mental healthcare provision (Figures E and F). The limitations of the survey data at the Institute for Public Policy and Social Research would not let me break down the perceptions of government privatization, however, making a direct comparison difficult.

Trust in Local Governments by Low Income Households

SDA 3.5: Tables

Michigan State of the State 70

Nov 30, 2016 (Wed 02:28 AM Eastern Standard Time)

Variables				
Role	**Name**	**Label**	**Range**	**MD**
Row	**D12**	Trust Government: Local	1-4	9,8
Column	**incca**	Income: Below $30,000	1-5	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

		incca		
		1 YES	5 NO	***ROW TOTAL***
D12	1: NEARLY ALWAYS OR MOST OF THE TIME	**37.8** 28	**36.5** 27	***37.2*** *55*
	2: SOME OF THE TIME	**37.8** 28	**43.2** 32	***40.5*** *60*
	3: SELDOM	**18.9** 14	**13.5** 10	***16.2*** *24*
	4: ALMOST NEVER	**5.4** 4	**6.8** 5	***6.1*** *9*
	COL TOTAL	***100.0*** *74*	***100.0*** *74*	***100.0*** *148*

Trust in Local Governments by Low Income Households

SDA 3.5: Tables

Michigan State of the State 70

Nov 30, 2016 (Wed 02:29 AM Eastern Standard Time)

Variables				
Role	**Name**	**Label**	**Range**	**MD**
Row	**D11**	Trust Government: State	1-4	9,8
Column	**incca**	Income: Below $30,000	1-5	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

		incca		
		1 YES	5 NO	***ROW TOTAL***
D11	1: NEARLY ALWAYS OR MOST OF THE TIME	**17.6** 13	**25.7** 19	***21.6*** *32*
	2: SOME OF THE TIME	**47.3** 35	**45.9** 34	***46.6*** *69*
	3: SELDOM	**28.4** 21	**18.9** 14	***23.6*** *35*
	4: ALMOST NEVER	**6.8** 5	**9.5** 7	***8.1*** *12*
	COL TOTAL	***100.0*** *74*	***100.0*** *74*	***100.0*** *148*

Recommendations

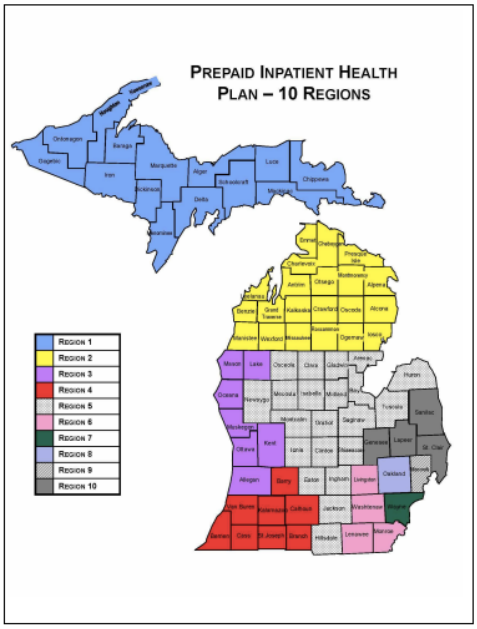
As local Michigan municipals continue to be fiscally stretched thin, and as the trend to privatize public services increases, the move to privatize health and human services is becoming increasingly pressing. Moving forward, I would recommend three policy proposals: 1) An increase in the data and information surrounding privatization of health and human services, 2) More government transparency in funds lost or gained through privatization of any and all services, and 3) Disapproval of Snyder's budget proposal to privatize mental health care.

First, I would call for more university or private company studies into the impacts of privatizing health and human services. To write this report, I had to rely on a handful of studies into this niche area of public policy, some of which were outdated for a few years — all making it difficult to understand the potential benefits and drawbacks of privatizing health and human services. As government outsourcing continues to increase, many local jurisdictions will look to privatize health services, as seen through Snyder's budget proposal. These decisions must be scrutinized and contextualized using more data into the impacts of these decisions.

Second, I would recommend more transparency into the revenue lost and gained through outsourcing services. Many officials have pointed out that outsourcing may not save funds as well as local jurisdictions say they do, even for engineering and legal services. Very little transparency currently exists as to the costs saved from these decisions. If more private-public partnerships are to occur in the future, the government needs to be as aggressive as ever in watchdogging private, for-profit companies and how they spend money from the government.

Finally, I would recommend the state of Michigan to not only refuse investing in private HMOs as part of Snyder's 2017 fiscal budget proposal, I would strongly oppose all statewide efforts to privatize health and human services in general, due to inconclusive evidence on the effectiveness of privatization and the transparency and oversight lost through contracting to for-profit organizations. In the future, moving to privatize mental health care could be a possibility, but without the information on the impacts of these decisions, as well as without grounded evidence that privatizing mental health care could save money, the government should not make risky decisions that may have unintended consequences for years to come.

Appendix



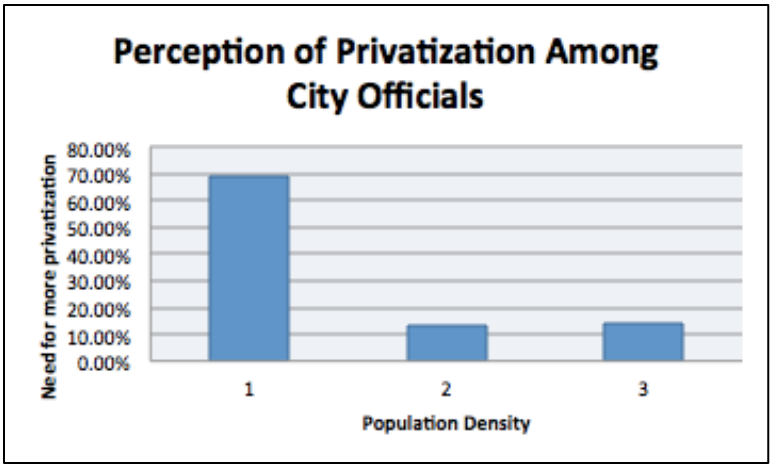


Figure A (top left)
Figure B (top right)
Figure C (bottom)

Most Common Problem for Michigan Residents by Political Party

SDA 3.5: Tables

Longitudinal SOSS Data File

Nov 30, 2016 (Wed 02:11 AM Eastern Standard Time)

Variables

Role	Name	Label	Range	MD
Row	**probcomm**	Most Important Problem Facing Community (A1)	1-95	99,98
Column	**partyid**	Respondents Political Party Identification	0-7	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

	partyid								
	0 Other/Nothing	1 Strong Republican	2 Not Strong Republican	3 Lean Republican	4 Neither, Independent	5 Lean Democrat	6 Not Strong Democrat	7 Strong Democrat	*ROW TOTAL*
1: SCHOOL FINANCE/EDUCATION FUNDING	1.2 11	2.0 43	3.0 55	2.5 47	1.9 33	3.2 75	2.6 53	1.9 66	*2.3* *383*
2: EDUCATION QUALITY/IMPROVE EDUCATION	4.7 44	2.9 61	3.8 70	2.7 51	3.4 60	3.8 89	3.5 72	3.2 114	*3.4* *561*
9: EDUCATION:GENERAL	3.2 30	2.8 59	2.7 50	1.9 35	2.1 37	1.6 39	2.5 51	1.9 67	*2.2* *368*
10: MEDICAL CARE/HEALTH CARE: GENERAL	2.2 21	1.9 39	2.0 37	1.2 23	1.7 29	1.8 43	1.6 33	1.8 64	*1.8* *289*
11: ELDERLY/MEDICAL CARE ELDERLY: MEDICARE	.6 6	.0 1	.2 4	.3 6	.4 7	.3 7	.4 8	.4 15	*.3* *54*
12: RACISM/EQUAL OPPORTUNITIES	1.3 12	.3 7	.5 9	.7 14	.7 13	.8 19	.9 19	.6 22	*.7* *115*
13: POVERTY/POOR	.5 5	.3 7	.9 16	.5 10	.6 11	.9 22	1.2 25	1.1 39	*.8* *135*
14: HOMELESSNESS	.1 1	.1 2	.2 4	.2 3	.2 4	.5 11	.5 10	.3 12	*.3* *47*
15: HOUSING/AFFORDABLE HOUSING	.5 5	.7 14	.8 14	.6 12	.2 3	.6 14	1.1 23	1.3 45	*.8* *130*
16: WELFARE REFORM/CUT WELFARE	1.2 11	.6 13	.5 10	.5 9	.2 3	.2 5	.6 12	.2 6	*.4* *69*
17: WELFARE EXPANSION/MORE PROGRAMS	.0 0	.0 0	.1 1	.0 0	.1 1	.0 1	.0 1	.0 0	*.0* *4*
19: OTHER (MEDICAL/HEALTH/WELFARE)	.3 3	.2 4	.2 3	.1 2	.4 7	.1 2	.4 8	.1 4	*.2* *33*

Most Common Problem for Michigan Residents by Household Income

SDA 3.5: Tables

Longitudinal SOSS Data File

Nov 30, 2016 (Wed 02:13 AM Eastern Standard Time)

Variables

Role	Name	Label	Range	MD
Row	**probcomm**	Most Important Problem Facing Community (A1)	1-95	99,98
Column	**income8**	Household Income in 8 Categories	1-8	0,9

Frequency Distribution

Cells contain:
-Column percent
-N of cases

	income8								
	1 Less than $10,000	2 $10,000-19,999	3 $20,000-29,999	4 $30,000-39,999	5 $40,000-49,999	6 $50,000-59,999	7 $60,000-69,999	8 $70,000 or more	*ROW TOTAL*
1: SCHOOL FINANCE/EDUCATION FUNDING	**1.1** 7	**1.3** 23	**1.6** 32	**2.5** 49	**2.1** 41	**2.4** 31	**2.6** 43	**3.3** 127	*2.3 353*
2: EDUCATION QUALITY/IMPROVE EDUCATION	**1.1** 7	**2.4** 42	**3.1** 60	**2.9** 57	**3.4** 67	**4.2** 54	**4.2** 70	**4.1** 161	*3.4 518*
9: EDUCATION:GENERAL	**.8** 5	**1.1** 20	**1.9** 37	**2.2** 43	**2.5** 49	**2.7** 34	**3.0** 50	**2.3** 90	*2.2 328*
10: MEDICAL CARE/HEALTH CARE: GENERAL	**2.3** 14	**1.7** 29	**1.6** 32	**2.1** 40	**1.8** 35	**1.8** 23	**1.9** 31	**1.7** 67	*1.8 271*
11: ELDERLY/MEDICAL CARE ELDERLY: MEDICARE	**1.0** 6	**.5** 9	**.2** 4	**.3** 6	**.2** 4	**.2** 3	**.4** 6	**.2** 8	*.3 46*
12: RACISM/EQUAL OPPORTUNITIES	**.8** 5	**.5** 8	**.9** 18	**.5** 10	**.9** 18	**.7** 9	**.7** 11	**.6** 24	*.7 103*
13: POVERTY/POOR	**1.3** 8	**1.3** 22	**1.0** 20	**.9** 18	**.9** 17	**.3** 4	**.6** 10	**.7** 26	*.8 125*
14: HOMELESSNESS	**1.0** 6	**.3** 6	**.4** 8	**.4** 7	**.1** 2	**.2** 2	**.2** 4	**.2** 8	*.3 43*
15: HOUSING/AFFORDABLE HOUSING	**1.3** 8	**1.0** 17	**.9** 17	**.7** 13	**.9** 18	**.9** 12	**.4** 7	**.6** 22	*.8 114*
16: WELFARE REFORM/CUT WELFARE	**.7** 4	**.4** 7	**.5** 9	**.2** 4	**.7** 13	**.2** 3	**.2** 4	**.5** 18	*.4 62*
17: WELFARE EXPANSION/MORE PROGRAMS	**.0** 0	**.0** 0	**.0** 0	**.0** 0	**.0** 0	**.0** 0	**.0** 0	**.1** 3	*.0 3*
19: OTHER (MEDICAL/HEALTH/WELFARE)	**.3** 2	**.3** 5	**.1** 2	**.1** 2	**.4** 7	**.1** 1	**.3** 5	**.1** 3	*.2 27*

Figure D

Trust in Local Governments by Low Income Households

SDA 3.5: Tables

Michigan State of the State 70

Nov 30, 2016 (Wed 02:28 AM Eastern Standard Time)

Variables

Role	Name	Label	Range	MD
Row	**D12**	Trust Government: Local	1-4	9,8
Column	**incca**	Income: Below $30,000	1-5	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

		incca		
		1 YES	5 NO	*ROW TOTAL*
D12	1: NEARLY ALWAYS OR MOST OF THE TIME	**37.8** 28	**36.5** 27	*37.2 55*
	2: SOME OF THE TIME	**37.8** 28	**43.2** 32	*40.5 60*
	3: SELDOM	**18.9** 14	**13.5** 10	*16.2 24*
	4: ALMOST NEVER	**5.4** 4	**6.8** 5	*6.1 9*
	COL TOTAL	*100.0 74*	*100.0 74*	*100.0 148*

Figure E (left)

Trust in Local Governments by Low Income Households

SDA 3.5: Tables

Michigan State of the State 70

Nov 30, 2016 (Wed 02:29 AM Eastern Standard Time)

Variables

Role	Name	Label	Range	MD
Row	**D11**	Trust Government: State	1-4	9,8
Column	**incca**	Income: Below $30,000	1-5	9,8

Frequency Distribution

Cells contain:
-Column percent
-N of cases

		incca		
		1 YES	5 NO	*ROW TOTAL*
D11	1: NEARLY ALWAYS OR MOST OF THE TIME	**17.6** 13	**25.7** 19	*21.6 32*
	2: SOME OF THE TIME	**47.3** 35	**45.9** 34	*46.6 69*
	3: SELDOM	**28.4** 21	**18.9** 14	*23.6 35*
	4: ALMOST NEVER	**6.8** 5	**9.5** 7	*8.1 12*
	COL TOTAL	*100.0 74*	*100.0 74*	*100.0 148*

Figure F (right)

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